

INDIAN HEALTH CARE AMENDMENTS OF 1984

OCTOBER 2, 1984.—Ordered to be printed

Mr. UDALL, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 2166]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2166) to authorize appropriations to carry out the Indian Health Care Improvement Act, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment to the text of the bill insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Indian Health Care Amendments of 1984".

REFERENCES

SEC. 2. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.).

TITLE I—INDIAN HEALTH MANPOWER

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 101. Subsection (c) of section 102 (25 U.S.C. 1612(c)) is amended to read as follows:

"(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

- "(1) \$550,000 for fiscal year 1985,*
- "(2) \$600,000 for fiscal year 1986,*
- "(3) \$650,000 for fiscal year 1987, and*
- "(4) \$700,000 for fiscal year 1988."*

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM

SEC. 102. (a) Section 103 (25 U.S.C. 1613) is amended by striking out subsection (d) and inserting in lieu thereof the following:

"(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

"(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

- "(1) \$4,000,000 for fiscal year 1985,*
- "(2) \$4,700,000 for fiscal year 1986,*
- "(3) \$5,400,000 for fiscal year 1987, and*
- "(4) \$6,100,000 for fiscal year 1988."*

(b) Subsection (c) of section 103 is amended by striking out "expenses" and inserting in lieu thereof "expenses of a grantee while attending school full time".

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 103. Section 105 (25 U.S.C. 1614) is amended by striking out subsection (d) and inserting in lieu thereof the following:

"(d) No stipend may be paid to any person under section 103 or 104 while such person is employed under this section.

"(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

- "(1) \$300,000 for fiscal year 1985,*
- "(2) \$350,000 for fiscal year 1986,*
- "(3) \$400,000 for fiscal year 1987, and*
- "(4) \$450,000 for fiscal year 1988."*

CONTINUING EDUCATION ALLOWANCES

SEC. 104. Subsection (b) of section 106 (25 U.S.C. 1615(b)) is amended to read as follows:

"(b) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

- "(1) \$500,000 for fiscal year 1985,*
- "(2) \$526,300 for fiscal year 1986,*
- "(3) \$553,800 for fiscal year 1987, and*
- "(4) \$582,500 for fiscal year 1988."*

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 105. Title I is amended by adding at the end thereof the following new section:

"INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

"SEC. 107. (a) In order to provide health professionals to Indian communities, the Secretary, acting through the Service and in ac-

cordance with this section, shall make scholarship grants to Indians who are enrolled full time in schools of medicine, osteopathy, dentistry, veterinary medicine, nursing, optometry, public health, and allied health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 2541) except as provided in subsection (b) of this section.

"(b)(1) The Secretary, acting through the Service, shall determine who shall receive such scholarships and shall determine the distribution of such scholarships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.

"(2) An individual shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full time in a health-profession school referred to in subsection (a).

"(3) The active duty service obligation prescribed under section 338B of the Public Health Service Act (42 U.S.C. 254m) shall be met by a recipient of an Indian Health Scholarship by service in the Indian Health Service, including service under a contract under the Indian Self-Determination and Education Assistance Act (Public Law 93-638); in a program assisted under title V of this Act; or in the private practice of his profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(c) For the purpose of this section, the term 'Indian' has the same meaning given that term by subsection (c) of section 4 of this Act, including all individuals described in clauses (1) through (4) of that subsection.

"(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) \$6,100,000 for fiscal year 1985,

"(2) \$7,000,000 for fiscal year 1986,

"(3) \$8,100,000 for fiscal year 1987, and

"(4) \$9,234,000 for fiscal year 1988."

TITLE II—HEALTH SERVICES

IMPROVEMENT OF INDIAN HEALTH STATUS

SEC. 201. (a) Section 201 is amended to read as follows:

"INDIAN HEALTH CARE IMPROVEMENT FUND

"SEC. 201. (a)(1) To further implement the national policy of raising the health status of Indians to a zero level of deficiency as defined in subsection (c) by eliminating backlogs in health care services and meeting unmet Indian health needs as soon as possible and in an equitable manner, the Secretary is authorized to expend, through the Service, over the 4-year period beginning with fiscal year 1985 the amounts authorized to be appropriated by subsection (h) of this section. Funds requested under this section shall be separately stated in the Service budget request as submitted to Congress under section 1105 of title 31, United States Code, and funds appro-

appropriated under this section shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13) or any other law. Funds appropriated under this section in any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(2) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs of the Service, nor is it intended to discourage the Service from undertaking additional efforts to achieve parity among tribes.

"(b)(1) Funds appropriated under this section shall be expended to augment the ability of the Service to meet the following health service responsibilities—

"(A) clinical care (direct or indirect);

"(B) preventive health;

"(C) dental care (direct or indirect);

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism among Indians;

"(G) accident prevention programs;

"(H) community health representative programs; and

"(I) maintenance and repair.

"(2) Where any funds allocated to a service unit are used for a contract under the Indian Self-Determination and Education Assistance Act, not more than 15 percent of such funds shall be used for health planning, training, technical assistance, and other administrative support functions.

"(3) To the extent that all or a portion of the funds appropriated under subsection (h) are required to raise service units which are below a Level II deficiency, as defined in subsection (c)(2), to such level, such funds shall not be available for allocation to service units at or above such level. Funds appropriated under this section shall be allocated on a service unit basis and apportionment of a service unit's allocation of funds among the health service responsibilities listed in paragraph (1) shall be as determined by the Service and the affected Indian tribe or tribes.

"(c)(1) Within sixty days of the date of enactment of the Indian Health Care Amendments of 1984, the Secretary shall submit to the Congress the current health services priority system report of the Service for each service unit including units serving newly recognized or acknowledged tribes. Such report shall contain—

"(A) the methodology for determining tribal health resources deficiencies; the level of health resources deficiency for each service unit; the amount of funds necessary to raise all service units below a Level II deficiency to a Level II deficiency; the amount of funds necessary to raise all service units below a Level I deficiency to a Level I deficiency; and the amount of funds necessary to raise all service units to a zero level of deficiency; and

“(B) an estimate of—

“(i) the amount of health service funds appropriated under the authority of this or any other Act for the preceding fiscal year which is allocated to each service unit or comparable entity; and

“(ii) the number of Indians eligible for health services in each service unit.

“(2) For purposes of this section, health resources deficiency levels shall be defined as follows:

“Level I—0 to 20 percent deficiency,

“Level II—21 to 40 percent deficiency,

“Level III—41 to 60 percent deficiency,

“Level IV—61 to 80 percent deficiency, and

“Level V—81 to 100 percent deficiency.

“(3) The Secretary shall establish by regulation procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of the service unit through which such tribe receives health services.

“(d) Upon enactment of the Indian Health Care Amendments of 1984, the Secretary, acting through the Service, shall take all necessary action, in cooperation with each Indian tribe, to bring current the tribal specific health plans which were developed as a part of the plan required by section 703 of this Act and which formed the basis for such plan in response to the requirements of section 701 of this Act. These plans shall be based upon the methodology submitted under subsection (c), as may be further modified through tribal consultation, and shall form the basis for the health services priority system report to be submitted by the Secretary for fiscal years 1986, 1987, and 1988. Such reports shall be submitted to the Congress not more than thirty days after the submission of the annual budget for such fiscal years to the Congress by the President.

“(e) The Secretary, acting through the Service, shall expend directly or by contract, including contracts under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), not less than 1 percent of the funds appropriated under subsection (h) for research in the areas of Indian health care set out in subparagraphs (A) through (G) of subsection (b)(1).

“(f) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated pursuant to subsection (h) on an equal basis with programs that are administered directly by the Indian Health Service.

“(g) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to carry out subsection (d) and to carry out each of the subparagraphs of subsection (b)(1).

“(h) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

“(1) \$28,000,000 for fiscal year 1985,

“(2) \$29,000,000 for fiscal year 1986,

“(3) \$28,000,000 for fiscal year 1987, and

“(4) such sums as may be necessary for fiscal year 1988.

Any funds appropriated under this subsection shall be designated as the 'Indian Health Care Improvement Fund'."

CATASTROPHIC HEALTH PROGRAM

SEC. 202. Title II is amended by adding at the end thereof the following new section:

"CATASTROPHIC HEALTH EMERGENCY FUND

"SEC. 202. (a) There is established an Indian Catastrophic Health Emergency Fund (hereinafter in this section referred to as the 'Fund') to be administered by the Secretary, acting through the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Service. The Fund shall be administered by the central office of the Service and shall not be allocated, apportioned, or delegated on a service unit or area office basis. Funds appropriated under subsection (c) shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13) or any other law. No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

"(b) The Secretary shall, through the promulgation of regulations consistent with the provisions of this section—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment, whether provided under contract or directly by the Service, would qualify for payment from the Fund; and which shall provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster shall have reached a certain threshold cost which the Secretary shall establish at not less than \$10,000 or not more than \$20,000;

"(2) establish a procedure for the reimbursement of service units or facilities rendering treatment or, whenever otherwise authorized by the Service, the reimbursement of non-Service facilities or providers rendering treatment;

"(3) establish a procedure for payment from the Fund where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(4) establish a procedure that will assure that no payment shall be made from the Fund to any provider to the extent that the provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible or by which the patient is covered.

"(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) \$12,000,000 for fiscal year 1985, and

"(2) for each of the fiscal years 1986, 1987, and 1988, such sums may be necessary to maintain the Fund at \$12,000,000.

Funds appropriated under this subsection shall remain available until expended.

"(d) By no later than January 1, 1988, the Secretary shall report to Congress on the operation of the Fund. Such report shall include—

"(1) the number and nature of disasters and catastrophic illnesses for which reimbursement was sought;

"(2) the costs associated with these disasters or illnesses;

"(3) the amounts reimbursed by the Fund in connection with such illnesses and disasters;

"(4) the effect of the Fund on the ability of the service unit to meet the health needs of their Service populations; and

"(5) the Secretary's recommendations regarding the future operation of the Fund."

COMPETITIVE PROCUREMENT

SEC. 203. Title II is amended by adding at the end thereof the following new sections:

"COMPETITIVE PROCUREMENT

"SEC. 203. (a) Notwithstanding any other provision of law, the Secretary, acting through the Service, may waive any statutory or administrative requirement for competitive procurement of health services if, in the judgment of the Chief Medical Officer who will have jurisdiction over such health services, such competitive procurement would compromise the accessibility, quality, and continuity of health services or would not result in any appreciable competition or savings.

"(b) Notwithstanding any other provision of law, the Secretary, acting through the Service, shall reject any bid submitted under any statutory or administrative requirement for competitive procurement of health services upon the certification of the Chief Medical Officer who will have jurisdiction over such health services that acceptance of such bid would compromise the accessibility, quality, and continuity of health services.

"DEMONSTRATION PROGRAM REGARDING ELIGIBILITY OF CERTAIN INDIANS FOR MEDICAL AND HEALTH SERVICES

"SEC. 204. (a) There is hereby established a demonstration program under which the determination of the eligibility of any Indian for medical or health services provided by, or on behalf of, the Indian Health Service within the State of Montana shall be made without regard to the eligibility of such Indian for any medical or health assistance that is provided to indigents by the State of Montana or any political subdivision thereof (or any agency or instrumentality thereof) if—

"(1) such medical or health assistance provided by the State of Montana or any political subdivision thereof (or any agency or instrumentality thereof) is funded by the revenues from any tax imposed on real property, and

"(2) such Indian resides on a reservation or restricted Indian land which is not subject to taxation.

"(b) The demonstration program established under subsection (a) shall not apply with respect to any benefits provided under title XIX of the Social Security Act (medicaid).

"(c) The demonstration program described in subsection (a) shall terminate on September 30, 1988.

"(d) The Secretary shall evaluate the demonstration program established pursuant to subsection (a) and shall submit to the Congress a report on such evaluation by no later than the date that is 3 years after the date of enactment of the Indian Health Care Amendments of 1984."

TITLE III—HEALTH FACILITIES

SEC. 301. Section 301 (25 U.S.C. 1631) is amended to read as follows:

"HEALTH FACILITIES

"SEC. 301. (a)(1) Within sixty days after the date of enactment of the Indian Health Care Amendments of 1984, the Secretary shall submit to the Congress a report which shall set forth the current health facilities priority system of the Service and which shall include the planning, design, construction, or renovation needs for the ten top priority inpatient care facilities and the ten top priority ambulatory care facilities together with required staff quarters, the justification for such priority listings, and the projected cost of such projects. The report shall also include the methodology adopted by the Service in establishing priorities under its health facilities priority system.

"(2)(A) Within thirty days of the submission of the annual budget to the Congress by the President for each of the fiscal years 1986, 1987, and 1988, the Secretary shall submit to the Congress a report which complies with the requirements of paragraph (1).

"(B) In preparing such report in such fiscal years, the Service shall consult with tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities with funds from the Service under the Indian Self-Determination Act, and shall review the needs of these tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

"(3) The Service shall use the same criteria for each of the fiscal years 1985, 1986, 1987, and 1988 to evaluate the needs of facilities operated under contract under the Indian Self-Determination Act as it uses to evaluate the needs of facilities operated directly by the Service in such fiscal years.

"(4) The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into under the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the development of the health facility priority system."

"(b)(1) All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) for the planning, design, construction, or renovation of health facilities for the benefit of a tribe or tribes may be used for the expenses of such activities incurred by such tribe or tribes under contracts or grants under the Indian Self-Determination Act. The United States shall hold the title to any facility constructed under a grant provided under this section.

"(2) Any tribal contractor or grantee shall expend the funds described in paragraph (1) for the purpose for which appropriated pursuant to rules and regulations established by the Secretary for contracting and procurement.

"(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for facilities planning and design, construction, or renovation under the Act of November 2, 1921 (25 U.S.C. 13), the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

"(2) ensure, wherever practicable, that such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Commission on Accreditation of Hospitals.

"(d) The Secretary shall not close, under any existing authority, any Service hospital or other outpatient health care facility or any portion thereof unless he has submitted to the Congress at least one year prior to the planned closure date an evaluation of the impact of the proposed action which shall include the following factors—

"(1) accessibility of alternative health care resources for the service population;

"(2) cost-effectiveness of the closure;

"(3) quality of health care to be provided to the service population after closure;

"(4) availability of contract health care funds to maintain current levels of service; and

"(5) the views of the Indian tribe or tribes served by such facility on the planned closure.

"(e) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1986, 1987, and 1988, planning information documents for the construction of 10 Indian health facilities which—

"(1) comply with applicable construction standards, and

"(2) have been approved by the Secretary."

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. Section 302 (25 U.S.C. 1632) is amended to read as follows:

"SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

"SEC. 302. (a)(1) Congress finds that—

"(A) the provision of safe water supply and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

"(B) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

"(C) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater

than the short-term cost of providing such facilities and other preventive health measures;

"(D) many Indian homes and communities still lack safe water supply and sanitary sewage and solid waste disposal facilities; and

"(E) it is in the interest of the United States and it is the policy of the United States that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply and sanitary sewage and solid waste disposal facilities as soon as possible.

"(2) Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(b) Beginning in fiscal year 1985, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitary sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

"(c)(1) Within 60 days of the date of the enactment of the Indian Health Care Amendments of 1984, the Secretary shall report to Congress on the Service's sanitation facilities priority system. The Secretary, in preparing such report, shall uniformly apply the methodology for determining sanitation deficiencies to all Indian tribes. Such report shall identify the methodology for determining sanitation deficiencies; the level of deficiency for each Indian community or tribe; the amount of funds necessary to raise all communities to a level I deficiency; and the amount of funds necessary to raise all communities or tribes to a zero level of deficiency. For the purpose of such report—

"(A) a level I deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of routine replacement, repair, or maintenance needs;

"(B) a level II deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of capital improvements necessary to improve the facilities to meet the needs of the communities for domestic sanitation facilities;

"(C) a level III deficiency means a sanitation system which has an inadequate or partial water supply and sewage disposal facility which does not comply with applicable water supply and pollution control laws and regulations or which has no solid waste disposal facility;

"(D) a level IV deficiency means a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

"(E) a level V deficiency means the absence of a safe water supply and sewage disposal system.

Any tribe or community which lacks the operation and maintenance capability to meet pollution control laws and regulations shall be deemed to have a level III deficiency.

"(2)(A) Within 30 days of the submission of the annual budget to the Congress by the President for fiscal years 1986, 1987, and 1988, the Secretary shall submit a report to the Congress which meets the requirements of paragraph (1).

"(B) In preparing such report for each of the fiscal years 1986, 1987, and 1988, the Secretary, acting through the Service, shall consult with tribes and tribal organizations including those operating health care programs or facilities under contracts under the Indian Self-Determination and Education Assistance Act to determine the sanitation needs of each tribe.

"(d)(1) To clarify the powers conferred by subsection (a) of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) the Secretary, acting through the Service, is authorized to provide—

"(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities,

"(B) ongoing technical assistance and training in the management of utility organizations, and

"(C) operation and maintenance assistance for and emergency repairs to tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities in situations where the community or tribe or family is not financially or technically capable of performing the required emergency repairs with their own resources.

"(2)(A) This section is not intended to diminish the primary responsibilities of the Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operation and maintenance of sanitation facilities.

"(B) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a precondition for the provision or construction of such facilities and the Secretary may not require a tribe or community to accept a transfer of such facilities where he has determined the tribe or community does not have, or may not be reasonably expected to achieve, such capability.

"(e) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

"(1) funds appropriated pursuant to subsection (f), and

"(2) funds appropriated for the purpose of providing water supply or sewage disposal services, on an equal basis with programs that are administered directly by the Indian Health Service.

"(f)(1) There are authorized to be appropriated for each of the fiscal years 1985, 1986, 1987, and 1988, \$5,000,000 for the purpose of providing funds necessary to implement the expanded responsibilities of the Service under subsection (d).

"(2) In addition to the amount authorized under paragraph (1), there are authorized to be appropriated for each of the fiscal years 1985, 1986, 1987, and 1988, \$850,000 for the purpose of providing 30 new full-time equivalents for the Service which shall be used to

carry out the expanded responsibilities of the Service under subsection (d).”.

USE OF NON-SERVICE FUNDS FOR RENOVATION

SEC. 303. Section 305 (25 U.S.C. 1634) is amended to read as follows:

“EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION

“SEC. 305. (a) Notwithstanding any other provision of law, an Indian tribe is authorized to expend—

“(1) any funds of such tribe which are not held in trust by the Secretary of the Interior,

“(2) upon approval of the Secretary of the Interior, any funds held in trust by the Secretary of the Interior for the benefit of such tribe, and

“(3) any funds appropriated under Federal law which are not appropriated to the Secretary for expenditure through the Service,

for the purpose of making any major renovation or modernization of any Service facility or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination and Education Assistance Act (including an expenditure for the planning or designing of such renovation or modernization) if the requirements of subsection (b) are met.

“(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

“(1) does not require or obligate the Secretary to provide any additional employees or equipment,

“(2) is approved by the appropriate area director of the Service, and

“(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

“(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service from any project which has a higher priority under the health facility priority system of the Service.”.

BETHEL, ALASKA HOSPITAL

SEC. 304. Title III is amended by adding at the end thereof the following new section:

“BETHEL, ALASKA HOSPITAL

“SEC. 306. (a) If a final administrative ruling by the Department of the Interior holds that the Bethel Native Corporation is entitled to conveyance of the title to the real property described in subsection (d)(1) under the Alaska Native Claims Settlement Act, such ruling shall not be subject to judicial review and title to such property shall be conveyed to the Bethel Native Corporation.

“(b) The Secretary is authorized, notwithstanding any other provision of law, to enter into an agreement with Bethel Native Corpora-

tion for an exchange of the real property described in subsection (d)(1) for—

“(1) the lands described in subsection (d)(2), or

“(2) any other Federal property which Bethel Native Corporation would have been able to select under the Alaska Native Claims Settlement Act.

“(c)(1) If an agreement for the exchange of land is not entered into under subsection (b) by the date that is 90 days after the date of a ruling described in subsection (a), the Secretary shall negotiate the terms of an agreement (which shall be entered into by the Secretary only in accordance with paragraph (3)) under which—

“(A) the hospital and housing facilities of the Indian Health Service located on the land described in subsection (d)(1) are to be sold to Bethel Native Corporation at a price which enables the Indian Health Service to recover the actual amount expended in the construction of such hospital and housing facilities, and

“(B) such hospital and housing facilities are to be leased at a reasonable rate to the Indian Health Service.

“(2) The Secretary shall submit to the Congress any agreement negotiated under paragraph (1).

“(3) Any agreement negotiated under paragraph (1) shall be entered into by the Secretary on the date that is 90 days after the date on which such agreement is submitted to the Congress. Notwithstanding any other provision of law, the Secretary is authorized to take any action necessary to implement such agreement after the date on which such agreement is entered into by the Secretary.

“(d)(1) The real property referred to in subsection (a) is United States Survey No. 4000 other than the lands described in paragraph (2).

“(2) The lands referred to in subsection (b)(1) are the lands identified as tracts A and B in the determination AA-18959 of the Bureau of Land Management issued on September 30, 1983, pursuant to the Alaska Native Claims Settlement Act.

“(e) Nothing in this section or in any agreement negotiated under subsection (c)(1) shall affect the application of the requirement of section 1905(b) of the Social Security Act that the Federal medical assistance percentage be 100 percent with respect to services received through the hospital.”.

TITLE IV—ACCESS TO HEALTH SERVICES

GRANTS AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 401. (a) Section 404 (25 U.S.C. 1622) is amended—

(1) by striking out “and” at the end of subsection (a)(2) and inserting in lieu thereof “or”, and

(2) by striking out “shall include, but are not limited to,” in subsection (b) and inserting in lieu thereof “may include, as appropriate,” and

(3) by adding “or” at the end of subsection (b)(3).

(b) Section 404(c) (25 U.S.C. 1622(c)) is amended by striking out “and” after “1983,” and by inserting before the period a comma and “\$3,000,000 for the fiscal year ending September 30, 1985, \$3,500,000 for the fiscal year ending September 30, 1986, \$4,000,000 for the

fiscal year ending September 30, 1987, and \$500,000 for the fiscal year ending September 30, 1988".

MEDICARE PROVISIONS

SEC. 402. (a) *Section 1880 of the Social Security Act is amended—*

(1) in subsection (a), by striking out "A hospital or skilled nursing facility" and inserting in lieu thereof "A provider of services or a rural health clinic";

(2) in subsection (a), by striking out "hospitals or skilled nursing facilities (as the case may be)" and inserting in lieu thereof "facilities of that type";

(3) in subsection (b), by striking out "a hospital or skilled nursing facility" and inserting in lieu thereof "a provider of services or a rural health clinic";

(4) in subsection (b), by striking out "hospitals or skilled nursing facilities (as the case may be)" and inserting in lieu thereof "facilities of that type";

(5) in subsection (c), by striking out "any hospital or skilled nursing facility" and inserting in lieu thereof "any provider of services or rural health clinic";

(6) in subsection (c), by striking out "hospitals and skilled nursing facilities" each place it appears and inserting in lieu thereof in each instance "providers of services and rural health clinics"; and

(7) in subsection (d), by striking out "hospitals and skilled nursing facilities" and "hospitals and facilities", and inserting in lieu thereof in each instance "providers of services and rural health clinics".

(b) *Section 1880(c) of the Social Security Act is further amended—*

(1) by inserting after the first sentence the following: "In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the providers and rural health clinics of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such providers and rural health clinics in order to achieve compliance with the conditions and requirements of this title."; and

(2) by striking out "The preceding sentence" and inserting in lieu thereof "This subsection".

(c) *The amendments made by this section shall apply to services performed on or after the date of the enactment of this Act.*

MEDICAID PROVISIONS

SEC. 403. (a) *Section 1911 of the Social Security Act is amended by striking out "or skilled nursing facility" each place it appears and inserting in lieu thereof in each instance "skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan".*

(b) *Section 1911 of the Social Security Act is amended by adding at the end thereof the following new subsections:*

"(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under the State plan.

"(d) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) is entitled under a State plan approved under this title by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of this title. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements."

(c) Subsections (b) and (c) of section 402 of the Indian Health Care Improvement Act (42 U.S.C. 1396j, note) are repealed.

(d) The amendments made by this section shall apply to services performed on or after the date of the enactment of this Act.

DEMONSTRATION PROGRAM; STUDY

SEC. 404. Title IV is amended by adding at the end thereof the following new sections:

"DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

"SEC. 405. (a) The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (medicaid), or from any other third-party payor. The Federal medical assistance percentage under the medicaid program shall continue to be 100 percent for purposes of the demonstration program.

"(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of sections 1880(c) and 1911(d) of

the Social Security Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used in accordance with the regulations of the Indian Health Service applicable to funds provided by the Indian Health Service under any contract entered into under the Indian Self-Determination Act.

"(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Indian Health Service and to facilities participating in the medicare and medicaid programs.

"(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a), and shall require such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

"(4) Notwithstanding sections 1880(c) and 1911(d) of the Social Security Act, no payment may be made out of the special fund described in sections 1880(c) or 1911(d) of the Social Security Act for the benefit of any hospital or clinic which is participating in the demonstration program described in subsection (a).

"(c)(1) In order to be considered for participation in the demonstration program described in subsection (a), a hospital or clinic must submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

"(A) the Indian tribe or Alaska Native health organization contracts the entire operation of the Indian Health Service facility;

"(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act;

"(C) the facility meets any requirements which apply to programs operated directly by the Indian Health Service; and

"(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1986.

"(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1985, select no more than 4 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1986, and end on September 30, 1988.

"(d)(1) Upon the enactment of the Indian Health Care Amendments of 1984, the Secretary, acting through the Indian Health Service, shall commence an examination of—

"(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a), including any agree-

ments with States which may be necessary to provide for such direct billing under the medicaid program; and

“(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Indian Health Service medical records information on patients served under such demonstration program which is consistent with the medical records information system of the Service.

“(2) Prior to the commencement of the demonstration program described in subsection (a), the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

“(3) Prior to October 1, 1985, the Secretary shall determine any accounting information which a participant in the demonstration program described in subsection (a) would be required to report and shall provide funding for the development of any such accounting system by any facility which has been selected to participate in such demonstration program.

“(e) The Secretary shall submit an interim report to the Congress at the end of fiscal year 1987, and a final report at the end of fiscal year 1988, on the activities carried out under the demonstration program described in subsection (a), and an evaluation of whether such activities have fulfilled the objectives of such program. In the final report the Secretary shall provide a recommendation, based upon the results of such demonstration program, as to whether direct billing of, and reimbursement by, the medicare and medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations which are contracting the entire operation of a facility of the Indian Health Service.

“(f) The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) and the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

“STUDY OF BARRIERS TO PARTICIPATION

“SEC. 406. (a) The Secretary shall, in consultation with Indian tribes and tribal organizations, conduct a study of any barriers which may exist to the participation of Indians in programs established under title XVIII of the Social Security Act (medicare) or under title XIX of the Social Security Act (medicaid).

“(b) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1984, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

“(1) recommendations for legislation which—

“(A) would remove any barriers to participation identified in such study, and

“(B) would encourage participation by Indians in the programs described in subsection (a); and

“(2) estimates by service unit of—

"(A) the potential number of Indians eligible for medicare,

"(B) the potential number of Indians eligible for medic-

aid,

"(C) the number of Indians participating in the medicare program, and

"(D) the number of Indians participating in the medicaid program."

TITLE V—URBAN INDIAN HEALTH SERVICES

REVISION OF PROGRAM

SEC. 501. Title V (25 U.S.C. 1651, et seq.) is amended to read as follows:

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"PURPOSE

"SEC. 501. The purpose of this title is to encourage the establishment of programs in urban centers to make health services more accessible to urban Indians.

"CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

"SEC. 502. The Secretary, through the Service, shall enter into contracts with urban Indian organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in this title. The Secretary, through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with any urban Indian organization pursuant to this title.

"CONTRACTS FOR THE PROVISION OF HEALTH CARE OR REFERRAL SERVICES

"SEC. 503. (a) The Secretary, through the Service, shall enter into contracts with urban Indian organizations for the provision of health care or referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract shall include requirements that the urban Indian organization successfully undertake to—

"(1) determine the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

"(2) determine the current health status of urban Indians residing in such urban center;

"(3) determine the current health care needs of urban Indians residing in such urban center;

"(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

"(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

"(6) assist such health services resources in providing services to urban Indians;

"(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

"(8) provide basic health education to urban Indians;

"(9) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (6) through (8) of this subsection;

"(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

"(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) The Secretary, through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations to enter into contracts under this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center involved;

"(2) the size of the urban Indian population in the urban center involved;

"(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

"(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

"(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

"(B) any project funded under this title;

"(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary under this section;

"(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

"(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"CONTRACTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

"SEC. 504. (a) The Secretary, through the Service, may enter into contracts with urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of

urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under this section.

“(b) Any contract entered into by the Secretary under this section shall include requirements that—

“(1) the urban Indian organization successfully undertake to—

“(A) document the health care status and unmet health care needs of urban Indians in the urban center involved;

“(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

“(2) the urban Indian organization complete performance of the contract within one year after the date on which the Secretary and such organization enter into such contract.

“(c) The Secretary may not renew any contract entered into under this section.

“EVALUATIONS; CONTRACT RENEWALS

“SEC. 505. (a) The Secretary, through the Service, shall develop procedures to evaluate compliance with, and performance of, contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

“(b) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract.

“(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract is not renewed under this section.

“(d) In determining whether to renew a contract with an urban Indian organization under section 503, or whether to enter into a contract with an urban Indian organization under section 503 which has completed performance of a contract under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract under section 503, shall consider the results of the on-site evaluations conducted under subsection (b).

"OTHER CONTRACT REQUIREMENTS

"SEC. 506. (a) *Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935, as amended.*

"(b) *Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.*

"(c) *Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title, except that whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.*

"(d) *In connection with any contract entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.*

"(e) *Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.*

"REPORTS AND RECORDS

"SEC. 507. (a) *For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a quarterly report including—*

"(1) in the case of a contract under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) such other information as the Secretary may request.

"(b) *The reports and records of the urban Indian organization with respect to a contract under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.*

"(c) *The Secretary shall allow as a cost of any contract entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.*

“REPORTS REQUIRED

“SEC. 508. (a) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1984, the Secretary, through the Service, shall submit a report to Congress which assesses the health status and health care needs of urban Indians. The report shall—

“(1) specify the health care needs of urban Indians and, with respect to urban centers for which urban Indian organizations have entered into contracts under section 503, whether additional health care personnel are needed to meet such needs;

“(2) make recommendations for additional programs, technical assistance, funding, and additional health care personnel to meet the health care needs of all urban Indians; and

“(3) contain recommendations for legislation and administrative actions to achieve the national goal of providing the best possible health status for urban Indians.

“(b) By no later than April 1, 1988, the Secretary, through the Service and with the assistance of the urban Indian organizations that have entered into contracts under this title, shall review the program established under this title and submit to the Congress an assessment thereof and recommendations for any further legislative efforts the Secretary deems necessary to meet the purpose of this title.

“LIMITATION ON CONTRACT AUTHORITY

“SEC. 509. The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

“AUTHORIZATIONS

“SEC. 510. There are authorized to be appropriated for contracts under this title—

“(1) \$12,000,000 for fiscal year 1985,

“(2) \$13,200,000 for fiscal year 1986,

“(3) \$14,400,000 for fiscal year 1987, and

“(4) \$15,800,000 for fiscal year 1988.”

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

MANAGEMENT INFORMATION SYSTEM

SEC. 601. (a) Title VI is amended to read as follows:

“TITLE VI—INDIAN HEALTH SERVICE

“MANAGEMENT INFORMATION SYSTEM; ACCESS TO PATIENT’S RECORDS

“SEC. 601. (a)(1) The Secretary shall establish an automated management information system for the Service.

“(2) The information system established under paragraph (1) shall include—

“(A) a cost accounting system,

“(B) a patient care information system for each area served by the Service, and

"(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service.

"(3) By no later than September 30, 1985, the Secretary shall submit a report to Congress setting forth—

"(A) the activities which have been undertaken to establish an automated management information system,

"(B) the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system, and

"(C) the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years.

"(b) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service."

(b) The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

INDIAN HEALTH SERVICE PLACED WITHIN PUBLIC HEALTH SERVICE

SEC. 602. (a) Title VI, as amended by section 601 of this Act, is further amended—

(1) by redesignating section 601 as section 602, and

(2) by inserting after the heading of the title, the following new section:

"ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

"SEC. 601. (a) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as is or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary of Health and Human Services for Health, and shall not report to, or be under the supervision of, any other officer or employee of the Department of Health and Human Services.

"(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

"(c) The Secretary shall carry out through the Director of the Indian Health Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1984, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

"(2) all functions of the Secretary or the Department of Health and Human Services relating to the maintenance and operation of hospital and health facilities for Indians and the

planning for, and the provision and utilization of, health services for Indians; and

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (68 Stat. 674);

"(D) the Act of August 16, 1957 (71 Stat. 370);

"(E) the Indian Self-Determination and Education Assistance Act (Public Law 93-638); and

"(F) the Act of December 5, 1979 (93 Stat. 1056).

"(d)(1) Notwithstanding any other provision of law, the Secretary may not reorganize, alter, or discontinue the Indian Health Service or allocate or reallocate any function which this section specifies shall be performed by the Director of the Indian Health Service or by the Secretary of Health and Human Services through the Director of the Indian Health Service.

"(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

"(e)(1) The Director of the Indian Health Service shall have the authority—

"(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) The provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), but not the provisions of section 2 of Public Law 96-135 (25 U.S.C. 472a), shall apply to personnel actions taken with respect to positions within the Service.

"(3) The authority of the Director of the Indian Health Service to enter into contracts under this subsection shall be to such extent or in such amounts as are provided in appropriation Acts."

(b) Section 5315 of title 5, United States Code, is amended by adding at the end thereof the following new item:

"DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES."

(c)(1) All personnel, records, equipment, facilities, and interests in property that are administered by the Indian Health Service on the day before the date on which the amendments made by this section take effect shall be transferred to the Indian Health Service established by the amendment made by subsection (a) of this section.

(2) The requirements of section 601 of the Indian Health Care Improvement Act, as amended by this section, shall be met within 180 days after the date on which the amendments made by this section take effect.

(3) *The Secretary of Health and Human Services may waive the application of the Indian preference laws during the 180-day period beginning on the date on which the amendments made by this section take effect on a case-by-case basis for any temporary transfer which is necessary in order to implement the amendment made by subsection (a) of this section.*

(d) *The amendments made by this section shall take effect in accordance with the following provisions:*

(1) *If the report submitted to the Congress under section 603(c)(2) of this Act contains a determination by the Commission established under section 603(a) that the amendments made by this section will enhance the ability of the Indian Health Service to provide health services to Indians, the amendments made by this section shall take effect on the date such report is submitted to the Congress.*

(2) *If the report submitted to the Congress under section 603(c)(2) of this Act contains a determination by the Commission established under section 603(a) that the amendments made by this section will not enhance the ability of the Indian Health Service to provide health services to Indians, the amendments made by this section shall take effect on the date that is 6 months after the date on which such report is submitted to the Congress.*

SEC. 603. COMMISSION ON THE ORGANIZATIONAL PLACEMENT OF THE INDIAN HEALTH SERVICE.

(a) *There is hereby established a commission to be known as the "Commission on the Organizational Placement of the Indian Health Service" (hereafter in this section referred to as the "Commission").*

(b)(1)(A) *The Commission shall consist of seven members as follows:*

(i) *three members of the Commission appointed by the President pro tempore of the Senate, upon the recommendations of the Majority Leader and the Minority Leader of the Senate;*

(ii) *three members of the Commission appointed by the Speaker of the House of Representatives; and*

(iii) *the Secretary of Health and Human Services or any delegate of the Secretary of Health and Human Services.*

(B) *The six members described under clauses (i) and (ii) of subparagraph (A) shall be appointed from a list of nominees submitted to the President pro tempore of the Senate and the Speaker of the House of Representatives under subparagraph (C). The appointment of such members of the Commission shall be completed by no later than the date that is 45 days after the date of enactment of this Act.*

(C) *The President pro tempore of the Senate and the Speaker of the House of Representatives shall request the Comptroller General of the United States and each of the following organizations to submit the names of individuals who are qualified to serve as members of the Commission:*

(i) *the American Management Association,*

(ii) *the American College of Hospital Administrators,*

(iii) *the Joint Commission on Accreditation of Hospitals,*

(iv) *the Brookings Institution,*

- (v) the American Academy of Medical Directors,
- (vi) the Association of American Indian Physicians,
- (vii) the American Academy of Pediatrics,
- (viii) the National Association of Colleges of Obstetrics and Gynecology, and
- (ix) the American Public Health Association.

(D)(i) The Majority Leader and Minority Leader of the Senate shall make a recommendation under subparagraph (A)(i) only after consulting with the chairmen and the ranking minority members of the Select Committee on Indian Affairs and the Committee on Labor and Human Resources of the Senate.

(ii) The Speaker of the House of Representatives shall make appointments under subparagraph (A)(ii) only after consulting with the chairmen and the ranking minority members of the Committee on Interior and Insular Affairs and the Committee on Energy and Commerce of the House of Representatives.

(2) The members of the Commission shall be individuals who possess the demonstrated capacities to discharge the duties imposed on the Commission and who have expertise in management, health care, health care administration, or Indian health care.

(3) The Speaker of the House of Representatives and the President pro tempore of the Senate jointly may remove a member of the Commission only for neglect of duty or malfeasance in office.

(4) Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner in which the original appointment was made.

(5) The Commission shall elect a Chairman from among the members of the Commission described in clause (i) or (ii) of paragraph (1)(A).

(6) Five members of the Commission shall constitute a quorum for the transaction of business.

(7) Each member of the Commission shall be entitled to one vote which shall be equal to the vote of every other member of the Commission.

(8) The Commission may adopt such rules and regulations as may be necessary to establish its procedures and to govern the manner of its operations, organization, and personnel.

(c)(1) The Commission shall conduct a study of the effects of the amendments made by section 602 of this Act. Such study should include consideration of—

(A) the effect of such amendments on the ability of the Indian Health Service to provide health services to Indians,

(B) the effect of such amendments on the ability of the Public Health Service to carry out its functions,

(C) the effect of such amendments on the ability of the Indian Health Service to control its personnel and manage the programs for which the Indian Health Service is responsible, and

(D) the effect of such amendments on the ability of the Indian Health Service to control policy development for Indian health programs.

(2) By no later than the date which is 410 days after the date of enactment of this Act, the Commission shall submit to the Congress a report on the study conducted under paragraph (1). Such report shall include a specific determination by the Commission of wheth-

er the amendments made by section 602 of this Act will enhance the ability of the Indian Health Service to provide health services to Indians.

(d)(1) Subject to such rules and regulations as may be adopted by the Commission, the Chairman of the Commission shall have the power to—

(A) appoint, terminate, and fix the compensation without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, or of any other provision of law, relating to the number, classification, and General Schedule rates of such personnel as it deems advisable to assist in the performance of its duties, at rates not to exceed a rate equal to the maximum rate for GS-18 of the General Schedule under section 5332 of such title; and

(B) procure, as authorized by section 3109 of title 5, United States Code, temporary and intermittent services to the same extent as is authorized by law for agencies in the executive branch but at rates not to exceed the daily equivalent of the maximum annual rate of basic pay in effect for grade GS-18 of the General Schedule.

(2) Service of an individual as a member of the Commission, or employment of an individual by the Commission as an attorney or expert in any business or professional field, on a part-time or full-time basis, with or without compensation, shall not be considered as service or employment bringing such individual within the provisions of any Federal law relating to conflicts of interest or otherwise imposing restrictions, requirements, or penalties in relation to the employment of persons, the performance of services, or the payment or receipt of compensation in connection with claims, proceedings, or matters involving the United States. Service as a member of the Commission, or as an employee of the Commission, shall not be considered service in an appointive or elective position in the Government for purposes of section 8344 of title 5, United States Code, or comparable provisions of Federal law.

(e)(1) Each member of the Commission shall serve on the Commission without compensation.

(2) All members of the Commission shall be reimbursed for travel and per diem in lieu of subsistence expenses during the performance of duties of the Commission in accordance with subchapter I of chapter 57 of title 5, United States Code.

(f) The provisions of the Federal Advisory Committee Act shall not apply to the Commission established under this section.

(g)(1) The Commission is authorized to secure directly from any officer, department, agency, establishment, or instrumentality of the Government such information as the Commission may require for the purpose of this section, and each such officer, department, agency, establishment, or instrumentality is authorized and directed to furnish, to the extent permitted by law, such information, suggestions, estimates, and statistics directly to the Commission, upon request made by the Chairman of the Commission.

(2) Upon request of the Chairman of the Commission, the head of any Federal agency shall make any of the facilities and services of

such agency available to the Commission and detail any of the personnel of such agency (other than personnel of the Indian Health Service or the Health Resources and Services Administration) to the Commission, on a nonreimbursable basis, to assist the Commission in carrying out its duties under this section.

(3) The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(h) The Commission shall cease to exist on the date that is 30 days after the date the Commission submits the report required under subsection (c)(2).

(i)(1) The total amount of expenses which may be incurred by the Commission shall not exceed \$500,000.

(2) Expenses incurred by the Commission (while the Commission is in compliance with paragraph (1)) shall be paid out of funds appropriated to the Indian Health Service.

TITLE VII—MISCELLANEOUS

LEASING AND OTHER CONTRACTS

SEC. 701. Section 704 (25 U.S.C. 1674) is amended—

(1) by striking out “Notwithstanding”, and inserting in lieu thereof “(a) Notwithstanding”, and

(2) by adding at the end thereof the following new subsection:

“(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

“(1) title to;

“(2) a leasehold interest in; or

“(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Indian Health Service or by programs operated by tribes or tribal organizations to compensate such tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.”.

JUVENILE ALCOHOL AND DRUG ABUSE

SEC. 702. Section 706 (25 U.S.C. 1676) is amended to read as follows:

“JUVENILE ALCOHOL AND DRUG ABUSE

“SEC. 706. (a) Within ninety days of the date of enactment of the Indian Health Care Amendments of 1984, the Secretary shall enter into an agreement with the Secretary of the Interior and the Secretary of Education to coordinate the efforts of their Departments related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coordination of available resources and programs to combat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary shall publish such agreement in the Federal Register

within one hundred and twenty days of the date of enactment of the Indian Health Care Amendments of 1984.

“(b) The Secretary, acting through the Service and in consultation and cooperation with the Secretary of the Interior and the Secretary of Education, shall develop a program to provide training in—

“(1) preventive education;

“(2) the identification of juvenile alcohol and drug abusers; and

“(3) counseling techniques on juvenile alcohol and drug abuse.

Such training shall be provided to elementary and secondary teachers and counselors—

“(A) in schools operated by the Bureau of Indian Affairs;

“(B) in schools operated under contract with the Bureau of Indian Affairs; and

“(C) in public schools on or near Indian reservations (including public schools in Oklahoma and Alaska with significant numbers of Indian students).

The Service may provide such training either directly or through contract with qualified private or public entities.

“(c) The Secretary of the Interior, acting through the Bureau of Indian Affairs and in consultation with the Service, shall review existing literature and reports on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse, and shall make available the results of such review to the schools described in subsection (b).

“(d) The Secretary shall establish an Office of Alcohol and Drug Abuse within the Service which shall be responsible for the administration of the programs and authorities of the Service in the field of alcohol and drug abuse. The Office shall have assigned to it a number of full-time equivalent positions which shall be not less than eight full-time equivalent positions in the Central Office of the Service and one full-time equivalent position in each Service area and Program Office.

“(e) For the purpose of implementing subsection (b), there is authorized to be appropriated \$1,500,000 for each of the fiscal years 1985, 1986, 1987, and 1988.”

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 703. (a) Subsections (a) and (b) of section 707 (25 U.S.C. 1677) are amended to read as follows:

“(a) The Secretary, acting through the Service, shall enter into appropriate arrangements with the National Academy of Sciences to conduct a study of the health hazards to Indian miners and to Indians living on, or near Indian reservations or in Indian communities which result from development of nuclear resources. Such study shall include—

“(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

"(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal;

"(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 10-year period ending on the date of enactment of the Indian Health Care Amendments of 1984 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) an evaluation of the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of nuclear resource development.

To assist the Academy in conducting such study, the Secretary and the Secretary of the Interior shall furnish at the request of the Academy any information which the Academy deems necessary for the purpose of conducting the study. In addition, they shall cooperate with the Academy in obtaining information necessary to carry out the intent of the study.

"(b) Upon the completion of the study described in subsection (a), the Secretary, acting through the Service, shall develop, on the basis of the results of such study, a health care plan to address the health problems studied under subsection (a). The plan shall include—

"(1) methods for diagnosing and treating Indians currently exhibiting nuclear resource development related health problems;

"(2) preventive care for Indians who may be exposed to such health hazards as a result of nuclear resource development, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or otherwise affected by nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

"(3) a program of education for Indians who, by reason of their work or geographic proximity to nuclear development activities, may experience health problems.".⁹

(b) Subsection (c) of section 707 is amended by striking out "no later than the date eighteen months after the date of the enactment of this Act" and inserting in lieu thereof "by no later than the date which is 18 months after the date of enactment of the Indian Health Care Amendments of 1984".

(c) Subsection (f) of section 707 (25 U.S.C. 1677(f)) is amended to read as follows:

"(f) There are authorized to be appropriated \$750,000 for the purpose of conducting the study described in subsection (a). Such funds

shall remain available for expenditure until the date which is 18 months after the date such funds are appropriated."

**ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA; FORMERLY
RECOGNIZED TRIBES IN CALIFORNIA**

SEC. 704. (a)(1) Subsection (a) of section 708 (25 U.S.C. 1678(a)) is amended—

(A) by striking out "1984" and inserting in lieu thereof "1988", and

(B) by striking out "Indians in such State" and inserting in lieu thereof "members of federally recognized Indian tribes of Arizona".

(2) Subsection (c) of section 708 (25 U.S.C. 1678(c)) is amended to read as follows:

"(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) \$7,700,000 for fiscal year 1985,

"(2) \$8,242,000 for fiscal year 1986,

"(3) \$8,819,800 for fiscal year 1987, and

"(4) \$9,434,600 for fiscal year 1988."

ELIGIBILITY OF CALIFORNIA INDIANS

SEC. 705. Section 709 (25 U.S.C. 1679) is amended to read as follows:

"ELIGIBILITY OF CALIFORNIA INDIANS

"SEC. 709. The following California Indians shall be eligible for care from the Service:

"(1) Any Member of a federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(A) is living in California,

"(B) is a member of the Indian community served by a local program of the Service, and

"(C) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

Paragraph (4) shall not apply after September 30, 1988."

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 706. Section 710 (25 U.S.C. 1680) is amended to read as follows:

"CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

"SEC. 710. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara, shall be designated as a

contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.”.

CONTRACT HEALTH FACILITIES

SEC. 707. (a) Title VII is amended by adding at the end thereof the following new section:

“CONTRACT HEALTH FACILITIES

“SEC. 711. (a) The Indian Health Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service under the Indian Self-Determination Act—

“(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

“(2) for employee training,

“(3) for cost-of-living increases for employees, and

“(4) for any other expenses relating to the provision of health services,

on the same basis as such funds are provided to programs and facilities operated directly by the Indian Health Service.

“(b) In the case of eligible California Indians as defined by section 709 who are not members of Indian tribes or eligible for membership in such tribes, the Secretary may not enter into a contract to provide health services to such Indians under section 103 of the Indian Self-Determination Act if 51 percent of the adult population of such Indians object prior to the award of such contract through any legally established organization of Indians representative of such Indians, in which case the Secretary, acting through the Service, shall make alternate arrangements for the delivery of health care services to such Indians. Nothing in this section shall be construed to restrict or interfere with the right of any Indian tribe to contract for health services on behalf of its own members.”.

(b)(1) The Secretary of Health and Human Services shall determine whether the provisions of subsection (b) of section 711 of the Indian Health Care Improvement Act have interfered with the effective administration of contracts entered into under section 103 of the Indian Self-Determination Act (25 U.S.C. 450g).

(2) The Secretary of Health and Human Services shall submit to the Congress a report on the determination made under paragraph (1) by not later than the date that is 18 months after the date of enactment of this Act.

NATIONAL HEALTH SERVICE CORPS

SEC. 708. (a) Title VII, as amended by section 707 of this Act, is further amended by adding at the end thereof the following new section:

“NATIONAL HEALTH SERVICE CORPS

“SEC. 712. (a) The Secretary of Health and Human Services shall not—

“(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or

by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act; or

“(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.”

(b) The amendment made by subsection (a) of this section shall take effect as of October 1, 1983.

ADDITIONAL PROVISIONS

SEC. 709. Title VII, as amended by sections 707 and 708 of this Act, is further amended by adding at the end thereof the following new sections:

“SERVICE TO INELIGIBLE PERSONS

“SEC. 713. (a)(1) The Secretary, acting through the Service, may provide or authorize the provision of medical care, treatment, or benefits by the Service to persons who are not otherwise eligible for such services in health facilities maintained by the Service or contracted under the Indian Self-Determination and Education Assistance Act (Public Law 93-638) or through contract health care services, subject to the limitations of this section.

“(2) Persons eighteen years of age or under who are the natural or adopted children (including foster- and step-children), legal wards, or orphans of an eligible Indian person and who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall be eligible for all such services on the same basis and subject to the same rules as apply to eligible Indians until their nineteenth birthday. The existing and potential medical needs of such persons shall be taken into consideration by the Service in determining the need for, or the allocation of, its health resources. Any such person who has been determined to be legally incompetent prior to their nineteenth birthday shall remain eligible for such services until one year after the date such disability has been removed.

“(3) Non-Indian spouses of eligible Indians or spouses of Indian descent who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall not be eligible for such service unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. The medical needs of persons made eligible under this subsection shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

“(b)(1)(A) At the request of the Indian tribe or tribes included within the service area of any service unit of the Service, the Secretary may authorize the medical care and treatment of otherwise ineligible persons residing within such service area in health facilities maintained and operated by the Service.

“(B) Persons receiving medical care and treatment under this subsection shall be liable for the payment for such services under a fee schedule adopted by the Secretary which, in the judgment of the Secretary, shall result in reimbursement in an amount not less than the actual cost of providing the service. Fees collected under this subsection, including medicare or medicaid reimbursements under

titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility.

“(2)(A) Except as provided in subparagraph (B), where the governing body of an Indian tribe or, in the case of a multi-tribal service area, any Indian tribe revokes its concurrence to the provision of services under paragraph (1)(A), the Secretary’s authority to provide such service shall terminate at the end of the fiscal year following the fiscal year in which such revocation was adopted.

“(B) In California, in the case of a multi-tribal service area, unless 51 percent or more of the Indian tribes in the Service area revoke their concurrence to the provision of services under paragraph (1)(A), the authority to provide such service shall not be affected.

“(3)(A) In the case of health facilities operated directly by the Service, such medical care and treatment may be provided under this subsection only where the Secretary and the affected tribe or tribes have jointly determined that—

“(i) the provision of such service will not result in a denial or diminution of services to eligible Indian persons; and

“(ii) there is no reasonable alternative health facility or service, within or without the service unit area, available to meet the medical needs of such persons.

“(B) In the case of health facilities operated under contract under the Indian Self-Determination and Education Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under a contract with the Service under the Indian Self-Determination Act is authorized to determine the eligibility for such services of persons who are not otherwise eligible for such services. Such determination shall be in accordance with the requirements of this section.

“(4) The Service may continue to provide medical care, treatment, and benefits to persons not provided service under subsections (a) or (b) to achieve stability in a medical emergency, to prevent the spread of a communicable disease or otherwise deal with a public health hazard; to provide care to non-Indian women pregnant with an eligible Indian’s child for the duration of the pregnancy through post partum, or to immediate family members of an eligible person where such care is directly related to the treatment of the eligible person.

“(5) Hospital privileges in health facilities operated and maintained by the Service or operated under contract under the Indian Self-Determination and Education Assistance Act may be extended to non-Service health care practitioners under a plan adopted under subsection (d) of this section. Such non-Service health care practitioners shall not be regarded as employees of the Federal Government for purposes of sections 1346(b) and 2671 et seq. of title 28 of the United States Code relating to Federal tort claims even if providing services to eligible persons as a part of the condition under which privileges are extended.

**"RESTRICTIONS ON THE USE OF INDIAN HEALTH SERVICE
APPROPRIATIONS**

"SEC. 714. Unless otherwise specifically provided, any restriction placed on the use of appropriations for Indian health services shall not be interpreted—

"(1) to apply to the use of funds other than such appropriated funds by an entity with a contract with the Indian Health Service;

"(2) to prohibit the support of litigation with such other funds; or

"(3) to prohibit the promotion of public support for or opposition to any legislative proposal with such other funds.

"INFANT AND MATERNAL MORTALITY

"SEC. 715. (a) Not later than January 1, 1985, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1990:

"(1) Reduction of the rate of Indian infant mortality in each Area Office of the Service to twelve deaths per one thousand live births or to that of the United States population, whichever is lower.

"(2) Reduction of the rate of maternal mortality in each Area Office of the Service to five deaths per one hundred thousand live births or to that of the United States population, whichever is lower.

"(b)(1) The Secretary shall report to Congress on January 1 of each year beginning after fiscal year 1985 on the progress that has been made toward achieving the objectives described in subsection (a).

"(2) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in subsection (a).

"REDUCTION AND CONTROL OF HEPATITIS-B IN ALASKA

"SEC. 716. (a)(1) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1984, the Secretary, through the Service and in conjunction with the State of Alaska and the Centers for Disease Control, shall complete the implementation of a program to provide for—

"(A) screening and reporting of cases of,

"(B) vaccinations for the prevention of, and

*"(C) control of the incidence of,
hepatitis-B in Alaska.*

"(2) By no later than December 30, 1986, the Secretary shall submit to the Congress a report concerning the activities carried out under the program described in paragraph (1). The report shall include—

"(A) a description of any activities which, on the day the report is submitted, need to be carried out to control the incidence of hepatitis-B in Alaska, and

"(B) a schedule for the completion of such activities.

"(b) The Secretary shall include in the budget submitted under section 1105(a) of title 31, United States Code, for each of the fiscal years succeeding the fiscal year in which the Indian Health Care Amendments of 1984 are enacted, a request for budget authority for, and estimates of outlays for, a program to control the incidence of hepatitis-B in Alaska.

"CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

"SEC. 717. The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana. The Secretary is directed to conduct a population survey of Indians residing in the Trenton Service Area for the purpose of determining the basis for the distribution of equity health care funds and the provision of contract health care. Should the results of the population survey indicate that additional eligible members of the Turtle Mountain Band of Chippewa Indians reside outside the boundaries of the named North Dakota and Montana counties, the contract health service delivery area shall be defined to include those additional counties of North Dakota or Montana in which such eligible tribal members reside."

"STUDY OF HEALTH CARE NEEDS OF NATIVE HAWAIIANS AND OTHER NATIVE PACIFIC ISLANDERS

"SEC. 718. (a)(1) The Secretary shall conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders.

"(2) In conducting the study required under paragraph (1), the Secretary shall consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

"(b) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1984, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

"(1) an assessment of the access of, and barriers to, Native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services,

"(2) an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and

"(3) specific recommendations for the development of a national strategy to address such needs."

DEFINITIONS

SEC. 710. Section 4 (25 U.S.C. 1603) is amended by striking out subsections (i), (j), and (k), and by inserting in lieu thereof the following new subsections:

“(i) ‘Area Office’ means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographical area; and

“(j) ‘Service unit’ means an administrative entity within the Indian Health Service or a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act through which services are provided, directly and by contract, to the eligible Indian population within a defined geographic area.”

SEVERABILITY

SEC. 711. *If any provision of this Act, any amendment made by this Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the amendments made by this Act, and the application of such provision to persons or circumstances other than those to which it is held invalid shall not be affected thereby.*

And the House agree to the same.

That the Senate recede from its disagreement to the amendment of the House to the title of the bill, and agree to the same.

From the Committee on Interior and Insular Affairs:

MORRIS K. UDALL,
SAMUEL GEJDENSON,
JAMES F. McNULTY, Jr.,
BILL RICHARDSON,
DON YOUNG,
JOHN MCCAIN,

From the Committee on Energy and Commerce:

JOHN D. DINGELL,
JAMES H. SCHEUER,
HENRY A. WAXMAN,
TOM LUKEN,

Managers on the Part of the House.

From the Select Committee on Indian Affairs:

MARK ANDREWS,
BARRY GOLDWATER,
SLADE GORTON,
FRANK H. MURKOWSKI,
JOHN MELCHER,
DANIEL K. INOUE,
DENNIS DECONCINI,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2166) to authorize appropriations to carry out the Indian Health Care Improvement Act, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment to the text of the bill struck out all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment which is a substitute for the Senate bill and the House amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

TITLE I—INDIAN HEALTH MANPOWER

INDIAN HEALTH PROFESSION SCHOLARSHIPS: PRIVATE PRACTICE OPTION

Section 107(b)(3) of the conference agreement extends authority for the active duty service obligation of an Indian Health Scholarship recipient to be fulfilled in the private practice of his profession if such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians. The Senate recedes to the House on the issue of the private practice option, but Senate conferees wish to encourage the Secretary of Health and Human Services to more closely monitor those physicians that have elected to meet their active duty service obligation in private practice, in order to assure that such physicians are actually providing health care services to Indian people.

TITLE II—HEALTH SERVICES

INDIAN HEALTH CARE IMPROVEMENT FUND: AUTHORIZATIONS

The conference agreement adopts the authorization levels contained in S. 2166 for activities authorized by Title II of the conference report. The specific authorizations levels are intended to be used for the purpose of raising all service units to a Level II deficiency as defined in section 201(c)(2) of the conference report, and

for the updating of tribal specific health plans authorized by section 201(d) of the conference report.

INDIAN HEALTH CARE IMPROVEMENT FUND: RESOURCES REPORT

Section 201(c)(1)(B) directs the Secretary to submit a report to Congress which shall estimate the amount of health service funds appropriated under the authority of the Indian Health Care Improvement Act or any other Act for the preceding fiscal year which is allocated to each service unit or comparable entity. The managers intend that the required estimate will identify and fully document all alternate resources that are in fact available to the Indian Health Service (IHS) for the provision of health care to eligible Indians.

CATASTROPHIC HEALTH EMERGENCY FUND

As passed by the House, H.R. 4567 added a new section 202 to the Indian Health Care Improvement Act establishing an Indian Catastrophic Health Emergency fund. The purpose of the fund is to enable the IHS to meet the extraordinary costs associated with the treatment of catastrophic illnesses or medical disasters. In some cases, the occurrence of a catastrophic illness or sudden medical disaster within the responsibility of an IHS service unit quickly depletes the funds allocated to that service unit for contract health care. The result is that the service unit must further ration the funds available to meet routine health care needs for that fiscal year or IHS must reallocate funds from other service units of IHS programs. In either case, the result is a further reduction in available health care service. In addition, the potential for this kind of occurrence impairs the ability of a service unit to rationally allocate its contract health care funds throughout the year.

The House provision establishes the fund and provides that it shall be used solely to reimburse service units for the costs of treating catastrophic illnesses which are in excess of a certain threshold cost as determined by the Secretary (not less than \$10,000 or more than \$20,000). Section 202 authorizes the appropriation for \$12,000,000 for fiscal year 1985 and such sums as are necessary for fiscal years 1986, 1987, and 1988 to maintain the fund at a \$12,000,000 level.

The bill, as passed by the Senate, contained no similar provision. The Senate conferees have agreed to accept the House provision without amendment, except that an authorization for fiscal year 1988 was added to the House provision.

COMPETITIVE PROCUREMENT

Section 203 of the conference agreement authorizes the Secretary to waive any statutory or administrative requirement for competitive procurement of health services if, in the judgment of the Chief Medical Officer having jurisdiction over such health services, such competitive procurement would compromise the accessibility, quality, and continuity of health services, or would not result in any appreciable competition or savings. The managers intend that (1) the ability of the IHS to provide quality health care to Indian

people, and (2) the projected impact on the health status of Indian people, be the primary determinants of whether competitive procurement requirements are to be waived by the Secretary.

DEMONSTRATION PROGRAM REGARDING ELIGIBILITY OF CERTAIN INDIANS FOR MEDICAL AND HEALTH SERVICES

The conference agreement provides that, in determining an individual Indian's eligibility for IHS services, the IHS may not take into account an indigent Indian's eligibility for state- or county-provided health care (or financial assistance for such health care) if that health care is funded from taxes on real property, and if the individual indigent Indian resides on trust property which is not subject to such taxation.

The House strongly disagreed with this policy as originally set forth in section 204(a) of the Senate bill, but agreed to substitute language proposed by the Senate that would: (1) limit the application of the provision to the State of Montana; (2) authorize the provision for purposes of a 4-year demonstration program only; and (3) require that a report be submitted to Congress at the end of three years evaluating the impact of the Montana provision.

The conference agreement also excludes the Medicaid program from the scope of this provision. Thus, in determining the eligibility of an Indian residing in Montana for IHS services, the IHS shall take into account such Indian's eligibility, if any, for Medicaid. The conferees wish to emphasize that nothing in this provision is intended to impair in any way the entitlement of an otherwise eligible Indian to participate in Medicaid, even where those benefits are paid for in part by State or local funds derived from revenues raised from real property taxes.

The provision does not preclude an Indian, in his capacity as a citizen of the state in which he resides, from receiving state- or county-provided health care services or financial assistance for health care services that are provided to all state citizens.

The report to be submitted by the Secretary shall include the types of federal or state assistance provided to the State of Montana, or to any political subdivision thereof (or any agency or instrumentality thereof), or to local facilities, for purposes of delivering health care to the local community, particularly where those entities receive assistance to serve the local indigent population for the area served. The evaluation shall also indicate the number of Indian people that are represented in the indigent population for the area served.

TITLE III—HEALTH FACILITIES

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

The conference agreement makes a Congressional finding and declaration that sanitation facilities are essential to good health and that the adequacy or inadequacy of sanitation facilities in Indian communities is directly related to increases or reductions in the incidence of many diseases which plague Indian communities. The conference agreement also reaffirms the Congressional man-

date of the Act of July 31, 1959 (73 Stat. 267) that the Indian sanitation responsibility lies with the Indian Health Service.

The conferees note that the Office of Management and Budget (OMB) persists in its view that the responsibility to provide sanitation facilities for Indian tribes and communities is merely a public works, construction function, having no relation to the health of the Indian people. In addition, OMB asserts that there are alternative funding sources, particularly in the Department of Housing and Urban Development, and statutory authorization to provide these facilities. The record developed by the committees with jurisdiction over this matter establishes that the IHS is, and properly should be, the only agency with clear statutory authority to meet these needs and that the alternative methods offered by OMB are clearly inadequate to effectively meet the critical needs of Indian communities for sanitation facilities and services.

BETHEL ALASKA HOSPITAL

H.R. 4567, as passed by the House, added a new subsection (f) to section 301 of the Act to resolve a land ownership dispute between the Indian Health Service and the Bethel Native Corporation (BNC) of Bethel, Alaska. No similar provision is contained in the Senate bill.

The Bethel Native Corporation, a profit corporation organized by the Alaska Natives of Bethel, Alaska, pursuant to the Alaska Native Claims Settlement Act (ANCSA), selected certain lands as their entitlement under ANCSA. Subsequently, in 1979, the Indian Health Service (IHS) constructed a hospital on this land without the consent of BNC. In 1983 and, again, in 1984, the Bureau of Land Management (BLM) has determined the BNC, under ANCSA, is entitled to a conveyance of title to this land. This determination of BLM is currently on administrative appeal by the Department of Health and Human Services.

The House provision validates BNC's title to these lands and requires the Secretary of Health and Human Services to sell this hospital facility to the Native Corporation at a price which would recover the actual costs of the United States in constructing the facility and to lease the facility from the corporation to provide health services to the Alaska Natives.

The conferees agreed to a revised provision which conditions the conveyance of title to the land to BNC upon a final administrative ruling that BNC is entitled to that conveyance. If the ruling is that the Corporation has a right to the conveyance, the Secretary and the Corporation have 90 days within which to negotiate a land exchange. If no land exchange can be negotiated, the provision requires the Secretary to enter into the sale-leaseback agreement with the Corporation. This agreement would become effective 90 days after submission of the agreement to the Congress.

It is the intent of the conferees that the operation of the Bethel hospital under a sale-leaseback provision pursuant to this section shall not impair the right of such facility to the one hundred percent Federal reimbursement for the costs of services provided to Medicaid-eligible Alaska Native patients.

TITLE IV—ACCESS TO HEALTH SERVICES

GRANTS AND CONTRACTS WITH TRIBAL ORGANIZATIONS

The conference agreement extends for four years the current authority of the Secretary to make grants or enter into contracts with tribal organizations to assist individual Indians to establish eligibility for Medicare or Medicaid and to pay monthly premiums under Medicare Part B in cases of financial need. The conference agreement authorizes \$3 million for FY 1985, \$3.5 million in FY 1986, \$4 million in FY 1987, and \$500,000 in FY 1988 for this purpose. The agreement clarifies that tribal organizations may focus their efforts in a manner consistent with local circumstances: on improving Indian participation in the Medicare program, or on improving Indian participation in the Medicaid program, or on paying monthly Medicare Part B premiums on behalf of indigent Indians who are not eligible for Medicaid, or on some combination of these. Tribal organizations need not undertake all three functions in order to qualify for a grant or contract.

MEDICARE PROVISIONS

The conference agreement extends the current authority for participation of IHS facilities in the Medicare program to all IHS hospitals, skilled nursing facilities, home health agencies, and rural health clinics that meet the generally applicable Medicare conditions and requirements for payment. IHS providers and rural health clinics which do not meet all of the Medicare conditions and requirements are deemed to meet these conditions if they submit to the Secretary within 6 months of enactment of this legislation an acceptable plan for achieving compliance. This "deemed" status extends only for 12 months following the submission of an acceptable compliance plan; thereafter, if a facility is not in compliance with the Medicare conditions and requirements, it may not receive payments under the program.

The conference agreement modifies the requirement in current law that the Secretary retain Medicare payments made to IHS facilities in a special fund to be used to bring those facilities into compliance with applicable Medicare conditions and requirements. Under the agreement, the Secretary would be required to return from this fund to each IHS service unit no less than 50 percent of the Medicare payments to which IHS facilities in the service unit are entitled, if these payments are necessary to bring the facilities in the service unit into compliance with Medicare conditions and requirements. Once compliance has been achieved in a given service unit, the Secretary would be required to apply the Medicare revenues from the facilities in that service unit to assist non-complying facilities in other service units. The purpose of this amendment is to give IHS facilities, whether operated by the IHS or by tribal contractors, an incentive to assist qualified patients in establishing their eligibility for Medicare benefits and to bill for and collect the Medicare payments to which they are entitled. This provision is effective with respect to payments for services provided on or after enactment.

MEDICAID PROVISIONS

The conference agreement extends the current authority for participation of IHS facilities in the Medicaid program to any IHS facility which provides services of a type otherwise covered under a State's Medicaid plan, including health centers, health stations, and home health agencies. As with IHS hospitals and skilled nursing facilities, these other IHS facilities would be required to meet all of the conditions and requirements for participation in the applicable State's Medicaid plan. In cases where the facility has submitted to the Secretary, within 6 months of enactment of this legislation, an acceptable plan for achieving compliance with such conditions and requirements, the facility may participate in the Medicaid program for no more than one year.

The conference agreement modifies the current law requirement that the Secretary place Medicaid payments made to IHS facilities in a special fund to be used to bring those facilities into compliance with the applicable Medicaid conditions and requirements. From the reimbursements collected in this fund, the Secretary would be required to return to each IHS service unit at least 50 percent of the Medicaid payments to which IHS facilities in such service unit are entitled, if these payments are necessary to bring the facilities in the service unit into compliance with applicable Medicaid conditions and requirements. Once compliance has been achieved in a given service unit, the Secretary would be required to apply the Medicaid revenues from the facilities in that unit to the improvement of non-complying facilities in other communities. The purpose of this provision is to give IHS facilities, whether operated by the IHS or by tribal contractors, an incentive to assist qualified patients in establishing their eligibility for Medicaid benefits and to bill for and collect the Medicaid payments to which they are entitled. This provision is effective with respect to payments for services provided on or after enactment.

DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

The conference agreement directs the Secretary to establish a demonstration program, to begin no later than October 1, 1986, and to end on September 30, 1988, under which no more than four facilities that are owned by the IHS but are operated in their entirety by Indian tribes, tribal organizations, or Alaska Native health organizations, receive payments directly from the Medicare and Medicaid programs and any other third-party payor. Medicare and Medicaid revenues generated by these demonstration facilities will not be diverted to the special fund administered by the Secretary under sections 1880(c) and 1911(c) of the Social Security Act. The purpose of this demonstration program is to determine, consistent with Indian self-determination policy, whether the financial autonomy made possible by direct billing arrangements will improve the ability of these facilities to carry out their patient care missions.

In order to participate in this demonstration program, a facility must be (1) operated in its entirety by an Indian tribe, tribal organization, or Alaska Native health organization; (2) eligible to participate in the Medicare and Medicaid programs; (3) meet any re-

quirements which apply to programs operated directly by the IHS; and (4) accredited, no later than October 1, 1986, by the Joint Commission on the Accreditation of Hospitals. The facility must apply its Medicare and Medicaid revenues to making any improvements necessary to achieve compliance with Medicare and Medicaid conditions and requirements. The use of any surplus Medicare and Medicaid revenues would be governed by applicable IHS regulations.

STUDY OF BARRIERS TO PARTICIPATION

The conference agreement directs the Secretary, in consultation with Indian tribes and tribal organizations, to report to the Congress within 12 months of enactment on the barriers to Medicare and Medicaid participation by American Indians and Alaska Natives. Particularly with regard to Medicaid, Indian participation is far lower than would be suggested by the 27% poverty rate among the Indian population. The conferees are concerned that poor Indians who desire Medicaid coverage and who are qualified for Medicaid in the States in which they reside may be unable to establish their entitlement to these critical benefits due to unintended programmatic obstacles. The conference agreement requires the Secretary to estimate the number of Indians in each service unit who are potentially eligible for Medicaid or Medicare, and to provide the number actually participating in these programs in each service unit. The Secretary is to identify any such barriers that may exist at either the State or service unit level. The Secretary shall also provide recommendations for the removal of these barriers and for other measures which would encourage the participation of Indians and Alaska Natives in Medicare and Medicaid. While primary concern of the conferees lies with the barriers to participation by Indians otherwise eligible for these programs, the conferees also intend that the Secretary identify and make recommendations regarding any eligibility requirements or standards that have a particularly or disproportionately exclusionary effect upon indigent Indians.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

The conference agreement extends authority for the urban Indian health care program through fiscal year 1988. Although the Administration continues to propose the termination of the urban Indian health care program on the grounds that there exist alternative health resources to serve the urban Indian population, the Administration has failed to produce any evidence documenting such resources, despite the repeated requests of congressional committees. Instead, the committees participating in this conference have taken testimony from community health centers, and state and local health care providers which indicates that most providers of their kind have neither the resources nor the capacity to provide health care to the urban Indian population. In the absence of documented evidence of alternative health care providers with adequate resources and sufficient capacities to serve the urban Indian population, the managers strongly support the extension of this important program.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

MANAGEMENT INFORMATION SYSTEM: ACCESS TO PATIENT'S RECORDS

The conference agreement directs the Secretary to establish an automated management information system for the IHS, including a cost accounting system, a patient care information system for each area served by the IHS, and a privacy component that protects the privacy of patient medical and financial information held by the IHS. The conferees intend that, in developing a privacy component, the Secretary limit unauthorized disclosure of identifiable patient medical information to the maximum possible degree, consistent with the essential needs of law enforcement and public health agencies. A report to Congress setting forth the progress that the Secretary has made in establishing the automated management information system is due no later than September 30, 1985.

It is the intention of the conferees that the management information system be developed only after the IHS has made a thorough evaluation of its own information needs and those of tribal contractors and local service units. It is further the intent of the conferees that the IHS, in developing its management information system, consult closely with tribes and tribal organizations and make every effort to integrate tribal information systems with the IHS system. Finally, the managers intend that the privacy of patient information held by, or on behalf of the IHS, be the foremost consideration in the development of the management information system.

The conference agreement also provides that each patient whose care is provided or paid for by the IHS have reasonable access to his or her medical or health records. Medical or health records include any material that contains information relating to the health, examination, care, or treatment of a patient. The conferees intend that an IHS operated or funded facility allow patients (or their designated representatives) to inspect and copy their own medical or health records except where, in the exercise of reasonable medical judgment, the facility determines that disclosure of the records would cause grave mental or physical harm to the patient. The conferees further expect that, in those cases when a facility denies a patient access to his or her records, the facility promptly provide a written explanation of the reasons for denial.

ESTABLISHMENT OF INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

As passed by the House, section 8 of H.R. 4567 strikes obsolete language of the Indian Health Care Improvement Act and inserts a new provision which provides for the removal of the IHS from the Health Resources and Services Administration (HRSA) and for the creation of a new Office of Indian Health Service within the Public Health Service (PHS). In addition, it authorizes the new Office of Indian Health Service to submit its budget estimates directly to the President and OMB and to receive its appropriation directly from the President and OMB.

A similar provision was contained in S. 2166 when it was reported from the Senate Select Committee on Indian Affairs. However, the provision was stricken by an amendment on the Senate floor.

The responsibility for Indian health care was transferred from the Bureau of Indian Affairs in the Department of the Interior to the Department of Health, Education, and Welfare by the Act of August 5, 1954 (68 Stat. 674). After the establishment of the Department of Health and Human Services, the Indian health responsibility was vested in the Indian Health Service as a component Bureau of the Health Resources and Services Administration of the Public Health Service.

The Indian Health Service is the primary agency responsible for carrying out the unique legal, moral, and historical responsibility of the United States to provide health services to Indian tribes. In carrying out this responsibility, IHS administers a comprehensive health care and health service delivery system serving nearly one million Indian people. IHS services cover over 350 Indian tribes, Indian communities, and Alaska Native villages in 31 States. These services are provided, either directly or through contract, through 51 hospitals, 84 major health centers, and over 550 smaller health centers and satellite health clinics. In addition, various referral and direct services are provided to Indians in urban settings through 37 urban Indian health projects. The total authorized obligations of the IHS for fiscal year 1984 was \$836,363,000, and the authorized personnel positions for fiscal year 1984 totalled nearly 11,000. Yet, this agency is located at the lowest echelon of the Departmental hierarchy.

In testimony before the House and Senate committees which considered the Indian health legislation, Indian tribes and organizations complained of the low visibility of Indian health concerns within the Department. They noted that there were often long delays in obtaining critical policy decisions and policy implementation which, in some cases, imperiled life and limb. They complained that budget and resources needs for Indian health routinely failed to filter up through the bureaucratic overburden and, therefore, that Congress was often denied adequate information upon which to make informed appropriation or legislative judgments.

In response to this testimony, all three of the committees which considered the Indian health legislation included a provision elevating the Indian Health Service within the Department.

The House Committee on Interior and Insular Affairs, in its report on H.R. 4567, included a provision which provided for the establishment of an Office of Indian Health Service under the direction of an Assistant Secretary of Health and Human Services for Indian Health. The House Committee on Energy and Commerce reported H.R. 4567 with a provision removing IHS from HRSA and placing it within the PHS, and with a provision allowing IHS to submit its budget directly to the President. In developing a compromise of their differing versions of H.R. 4567, these two committees adopted the Energy and Commerce approach which, with amendments, was passed as a part of H.R. 4567.

The Senate Select Committee on Indian Affairs, in reporting S. 2166, also included a provision removing IHS from HRSA and es-

establishing it as a separate agency within the PHS. As noted, this provision was dropped through a Senate floor amendment.

In resolving the differences between the House and Senate bill, the conferees adopted a further compromise on this issue. First, the House receded on the House bill provision for the IHS budget by-pass.

The Senate agreed to accept the House provision establishing the IHS as a new Agency within the PHS. The compromise further provides that the establishment of the IHS as a PHS Agency would be delayed for 410 days after enactment. During this time, a Commission on the Organizational Placement of the Indian Health Service would be constituted. The Commission is to be composed of seven members. Six are to be selected from nominations submitted by named private or public organizations, three to be appointed by the Speaker of the House and three by the President pro tempore of the Senate. The chairperson of the Commission shall be elected from among these 6 members. The seventh member would be either the Secretary of Health and Human Services or his delegate. Appointments are to be made within 45 days after enactment.

The Commission is to evaluate whether the proposed elevation of the IHS within the PHS will enhance the ability of the IHS to provide health care to Indian people and to report its findings to the Congress within one year. If the Commission finds that the elevation will enhance the ability of the IHS to deliver health care to Indians, the section will take immediate effect. If the Commission finds that the proposed elevation will not achieve the intended result, implementation would be delayed for an additional six months so that Congress may have sufficient time to repeal the provision.

It is the conferees' intent that the primary focus of the Commission's evaluation is to be the trust responsibility of the United States to provide health care and health services to Indians and Indian tribes and the extent to which the elevation of the IHS to a PHS Agency would enhance or detract from that responsibility.

TITLE VII—MISCELLANEOUS

LEASING AND OTHER CONTRACTS

Section 704 of P.L. 94-437, the Indian Health Care Improvement Act of 1976, authorizes the Secretary of Health and Human Services to lease tribal facilities for health purposes for periods not in excess of 20 years. In addition, it permits the Secretary to reconstruct or renovate the leased facilities with the consent of the tribe. While it was the intent of Congress that this provision be given a liberal construction to further the improvement of Indian health and to provide a greater role for Indian tribes in the delivery of health care, some tribes have reported that they have encountered difficulty with the Department in the use of this authority, particularly in the area of allowable costs which could be included in the lease rentals.

The conference agreement amends section 704 to make clear the intent of the Congress that this provision should be liberally con-

strued with other applicable laws and to make clear the cost elements which may be included in lease rentals.

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

The 1980 amendments to P.L. 94-437 authorized the Secretary, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, to conduct a study of health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resource development. The study was required to include an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems; an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities; an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal; and any efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out education programs for such Indians regarding the health and safety hazards of such nuclear resource development. Rather than conducting the required study, the Secretary submitted a survey of existing literature on nuclear resource development to the Congress. The conference report reauthorizes the study of nuclear resource development health hazards, directs that the study be conducted by the National Academy of Sciences, and makes available \$750,000 for this purpose.

ELIGIBILITY OF CALIFORNIA INDIANS

The conference agreement provides that the following California Indians are eligible for care from the IHS: (1) any member of a Federally-recognized tribe; (2) any descendant of an Indian who was residing in California on June 1, 1852, and who is living in California, belongs to the Indian community served by a local program (including programs that may be established in the future), and is regarded as an Indian by the community in which he or she lives; and (3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California. The conference agreement further provides that, until September 30, 1988, any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such Indian, is eligible for care from the IHS. The purpose of this provision is to codify existing IHS policy and practice with respect to the eligibility of California Indians for IHS services. The California Indian population described in this section is eligible for the same range of services provided to eligible Indians outside of California, including direct and contract care.

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

The conference agreement follows the House provision designating the State of California as a contract health service delivery area, with the exception of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara counties. A number of counties that are included in the California contract health service delivery area under this provision are also served by urban Indian health projects receiving funds under Title V. These counties include Fresno, Kern, San Diego, and Ventura. It is the intent of the conferees that the urban Indian health projects in these counties continue to serve the urban Indians residing in the urban centers in which the projects are located. This provision is not to be construed as limiting in any way the need for urban Indian health projects.

CONTRACT HEALTH FACILITIES

The conference agreement follows the House provision directing the IHS to treat facilities and programs operated by Indian Self-Determination Act contractors on the same basis as facilities and programs operated directly by the IHS with respect to funding for all expenses relating to the provision of health services, including maintenance and repair, employee training, and cost-of-living increases.

The conference agreement further provides that, with respect to California Indians who are eligible for IHS services but are not members of Indian tribes, the Secretary may not contract under the Indian Self-Determination Act if 51 percent or more of the adult population of such Indians living in the area to be served by the contract have objected prior to the award of the contract. Under current law, the Secretary is authorized to contract for the provision of health services only with "the consent of the Indian people served." The Secretary has implemented this provision in contracts with tribes and tribal organizations, under the authority of the Indian Self-Determination Act, by obtaining resolutions of approval from the governing bodies of those tribes. In California, however, a substantial number of the Indian people served are not members of, or eligible for membership in, Indian tribes, and confusion exists concerning the extent of the Secretary's obligation to obtain consent in these circumstances. It is the purpose of this provision to eliminate this confusion by setting forth a concrete method for the Secretary to meet her obligation to obtain the consent of the non-affiliated Indians in California who receive health services through Indian Self-Determination Act contracts. The conferees are concerned about the impact this consent mechanism may have on the administration of contracting for health services under the Indian Self-Determination Act in California, and the conference agreement accordingly directs the Secretary to report to the Congress on this matter within 18 months of enactment.

NATIONAL HEALTH SERVICE CORPS

The conference agreement follows the House amendment prohibiting the Secretary from (1) removing a member of the National

Health Service Corps (NHSC) from an Indian site or (2) withdrawing the funding support for an NHSC member at such a site unless the Secretary has made certain that the Indians served by these NHSC members will experience absolutely no reduction in services. It is the intent of the conferees that, whatever arrangements the Secretary elects to make with regard to the withdrawal of NHSC members or funding at Indian sites, none of the facilities or programs at which NHSC members are currently placed experience any reduction in health care personnel or financial support as a result of such arrangements. Changes in NHSC placement policy do not, in the view of the conferees, justify any reductions in funding or positions for the affected facilities or programs.

RESTRICTIONS ON THE USE OF INDIAN HEALTH SERVICE APPROPRIATIONS

The conference agreement follows the House amendment providing that restrictions on lobbying and litigation applicable to funds appropriated to the IHS are not applicable to the use of private or non-IHS public funds by organizations that contract with the IHS, whether under the Indian Self-Determination Act, Title V of the Indian Health Care Improvement Act, or other authority.

INFANT AND MATERNAL MORTALITY

The conference agreement follows the House amendment directing the Secretary to develop and begin implementation, not later than January 1, 1985, of a plan to reduce (1) the rate of Indian infant mortality in each IHS Area or Program Office to the lower of 12 deaths per 1,000 live births, or that of the U.S. population; and (2) the rate of maternal mortality in each IHS Area or Program Office to the lower of the rate of 5 deaths per 100,000 live births or the U.S. population. The conference agreement does not authorize additional appropriations for this purpose. It is the intent of the conferees that these objectives be achieved through more focussed management of current IHS resources. The Secretary is directed to provide an annual estimate for the expenditures for this purpose for the most recently completed fiscal year.

REDUCTION AND CONTROL OF HEPATITIS B IN ALASKA

The Conference report authorizes a program for the reduction and control of Hepatitis B, which is intended to provide for screening and reporting of cases of, vaccinations for the prevention of, and control of the incidence of Hepatitis B in Alaska. It is the intention of the managers that the authorized activities also be undertaken in areas outside of State of Alaska where a substantial number of Eskimos, Aleuts, and Alaska Natives reside, or in areas outside the State of Alaska where the incidence of Hepatitis B among native people has been found to closely approximate the incidence of Hepatitis B among native populations in the State of Alaska.

CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

In order to conform with current IHS practice previously authorized by appropriations acts of Congress, the conference report designates the counties of Divide, McKenzie, and Williams in the State of North Dakota, and the counties of Richland, Roosevelt, and Sheridan in the State of Montana, as a contract health service delivery area for the provisions of services to eligible members of the Turtle Mountain Band of Chippewa Indians.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2166.
2. Bill title: Indian Health Care Amendments of 1984.
3. Bill status: As agreed to by the Senate Select Committee on Indian Affairs and the House Committees on Energy and Commerce and Interior and Insular Affairs on September 25, 1984.
4. Bill purpose: S. 2166 would revise and extend the Indian Health Care Improvement Act.
5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
Amounts Subject to Appropriations Action					
Estimated authorization levels:					
Health Professions Recruitment Program for Indians.....	0.6	0.6	0.7	0.7	.....
Health Professions Prep Scholarship Program for Indians.....	4.0	4.7	5.4	6.1	.....
Indian Health Scholarship Program.....	6.1	7.0	8.1	9.2	.....
Indian Health Service Extern Program.....	.3	.4	.4	.5	.....
Continuing Education Allowance.....	.5	.5	.6	.6	.....
Health Services.....	28.0	29.0	28.0	46.0	.....
Indian Catastrophic Health Emergency Fund.....	12.0	12.0	12.0	12.0	.....
Water and Sanitation.....	5.9	5.9	5.9	5.9	.....
Access to Health Services.....	3.0	3.5	4.0	.5	.....
Health Services for Urban Indians.....	12.0	13.2	14.4	15.8	.....
Training of BIA Teachers.....	1.5	1.5	1.5	.....	.....
Study of Health Hazards to Indians from Nuclear Development.....	.5	.3	.....	.....	.....
Arizona as a Contract Health Service Delivery Area.....	7.7	8.2	8.8	9.4	.....
Hepatitis-B Screening and Vaccination in Alaska.....	.....	1.0	1.1	1.2	1.2
Total estimated authorization levels.....	82.1	87.8	90.9	107.9	1.2
Estimated outlays:					
Health Professions Recruitment Program for Indians.....	0.4	0.6	0.6	0.7	0.1
Health Professions Prep Scholarship Program for Indians.....	3.2	4.4	5.2	5.9	1.2
Indian Health Scholarship Program.....	4.9	6.6	7.8	9.0	1.8
Indian Health Service Extern Program.....	.2	.3	.4	.4	.1
Continuing Education Allowance.....	.4	.5	.6	.6	.1
Health Services.....	22.5	27.8	28.1	42.5	8.3
Indian Catastrophic Health Emergency Fund.....	9.7	11.5	12.0	12.0	2.3
Water and Sanitation.....	1.5	4.3	5.3	5.7	4.4
Access to Health Services.....	2.4	3.3	3.9	1.2	.2
Health Services for Urban Indians.....	9.7	12.5	14.1	15.6	3.0
Training of BIA Teachers.....	1.2	1.4	1.5	0.3	.....
Study of Health Hazards to Indians from Nuclear Development.....	.4	.3	.....	.....	.....
Arizona as a Contract Health Service Delivery Area.....	6.2	7.8	8.6	9.3	1.8
Hepatitis-B Screening and Vaccination in Alaska.....	.....	.8	1.0	1.2	1.2
Total estimated outlays.....	62.7	82.1	89.1	104.4	24.5

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
Direct spending provisions:					
Medicare:					
Budget authority.....	.2	.2	.1	.1	.....
Estimated outlays.....	.8	.8	.8	.8	.8
Grand total:					
Budget authority/authorization levels.....	82.3	88.0	91.0	108.0	1.2
Estimated outlays.....	63.5	82.9	89.9	105.2	25.3

The costs of this bill fall within function 550 and 570.

Basis of estimate: This estimate was prepared on the basis of preliminary drafts of the bill and conversations with Committee staff. Final legislative language was unavailable.

Most authorization levels are stated in the bill. CBO assumes that all stated authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

The Indian Health Care Improvement Fund authorization level for fiscal years 1985 through 1987 was determined using figures provide by the Indian Health Service (IHS). They estimate that a total of \$70 million is needed to raise 184 Indian tribes to a level where they have a 40 percent deficiency of health resources. These funds would be authorized over a three year period, as stated in the bill.

The bill authorizes such sums as may be necessary for fiscal year 1988 to begin to raise an additional 45 tribes to a 20 percent deficiency level. According to IHS, this would require an additional \$138 million. It is the Committee's intent, however, that these funds be authorized over the three-year period of fiscal years 1988 to 1990. Only one third of this amount, \$46 million, would be authorized in fiscal year 1988.

The bill also authorizes \$12 million in fiscal year 1985 for the Indian Catastrophic Health Emergency Fund. It authorizes such sums as may be necessary in fiscal years 1986, 1987 and 1988 to return the Fund to a level of \$12 million. CBO assumes that this authorization would not allow repeated draining and refilling of the Fund during any one fiscal year. Rather, the authorization will simply limit aggregate annual appropriations to the Fund to \$12 million.

No additional appropriations were authorized in this bill for Hepatitis-B screening and vaccination for Alaska natives, although the bill language provides for these services. This program is currently authorized at \$1 million in fiscal year 1985, its third and final year of specific authorization. CBO assumes that additional appropriations would be needed in fiscal years 1986 through 1989 to continue these activities. The amounts were calculated by increasing the 1985 authorization level of \$1 million by the appropriate program inflator. This estimate includes the cost of the Hepatitis B screening and vaccinations permitted by this bill because such activities would fall under the permanent, unspecific authorization of the Snyder Act of 1921.

This bill would also expand the types of Indian health facilities eligible for Medicare reimbursement. Medicare facilities would be expanded to include health centers, health stations, and home health agencies. Because most facilities are already covered by Medicare, this legislation would have only a very small cost.

The bill also newly designates California as a contract health service delivery area and provides funding for employee training, cost-of-living adjustments and maintenance and repair in tribally operated IHS programs and facilities. The bill also authorizes the development and implementation of a plan to reduce infant and maternal mortality rates among Indians. The Secretary of HHS is also authorized to establish a management information system for IHS. CBO has not included an estimate for these new activities as it is the Committees' intent that they be funded from current resources.

6. Estimated cost to State and local governments: This bill would set up a four year demonstration project in Montana that would prohibit IHS from considering an indigent Indian's eligibility for state and local health care programs funded by real estate taxes. Since IHS has traditionally been a residual resource for payment for contract care, counties have been paying for these services to indigent Indians residing in their jurisdictions. This new provision would make IHS the primary payor of contract care for this group even if they are eligible for county programs. The provision would have the largest impact on Roosevelt and Hill counties in Montana. Based on these two counties' current level of outstanding medical claims against the IHS, they could save about \$100,000 in each of the four years as a result of enactment of this legislation.

7. Estimate comparison: CBO prepared an estimate for H.R. 4567 as ordered reported by the House Committee on Interior and Insular Affairs, on May 9, 1984 and as ordered reported by the House Committee on Energy and Commerce, on May 16, 1984. We also prepared an estimate for H.R. 6039 as introduced and referred to the House Committee on Interior and Insular Affairs and to the House Committee on Energy and Commerce, on July 30, 1984. We prepared an estimate for S. 2166, the Indian Health Care Amendments of 1984, as ordered reported from the Senate Select Committee on Indian Affairs on May 14, 1984. All of these bills revise and extend the Indian Health Care Improvement Act. The cost estimates for all these bills are similar to each other and to this estimate. However, none are identical because of differences in the individual bills.

8. Previous CBO estimate: None:

9. Estimate prepared by: Carmela Pena.

10. Estimate approved by: C. G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

From the Committee on Interior and Insular Affairs:

MORRIS K. UDALL,
SAMUEL GEJDENSON,
JAMES F. McNULTY, Jr.,
BILL RICHARDSON,
DON YOUNG,
JOHN MCCAIN,

From the Committee on Energy and Commerce:

JOHN D. DINGELL,
JAMES H. SCHEUER,
HENRY A. WAXMAN,
TOM LUKE,

Managers on the Part of the House.

From the Select Committee on Indian Affairs:

MARK ANDREWS,
BARRY GOLDWATER,
SLADE GORTON,
FRANK H. MURKOWSKI,
JOHN MELCHER,
DANIEL K. INOUE,
DENNIS DECONCINI,

Managers on the Part of the Senate.

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